IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, ET AL.,	
Plaintiffs,	CV No. 18-2340
vs.	Washington, D.C.
CVS HEALTH CORPORATION, ET AL.,	June 4, 2019
Defendants.	10:45 a.m.
	Day 1
	Morning Session

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE RICHARD J. LEON
UNITED STATES SENIOR DISTRICT JUDGE

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P R O C E E D I N G S

DEPUTY CLERK: All rise. The United States District Court for the District of Columbia is now in session, the Honorable Richard J. Leon presiding. God save the United States and this Honorable Court. Please be seated and come to order.

The matter before the court is Civil Action No. 18-2340, the United States of America, et al., versus CVS Health Corporation, et al.

Counsel, please come forward and state your names for the record.

MR. OWEN: Good morning, Your Honor. Jay Owen representing the United States.

THE COURT: Welcome.

MR. FITZGERALD: Good morning, Your Honor. Scott Fitzgerald, also on behalf of the United States.

THE COURT: Welcome.

MR. MUCCHETTI: Good morning, Your Honor. Peter Mucchetti on behalf of the United States.

THE COURT: Welcome.

MR. ALVARADO: Good day, Your Honor. Jesus M. Alvarado-Rivera on behalf of the United States.

THE COURT: Are you all antitrust division?

MR. OWEN: Yes, Your Honor.

THE COURT: How many have you got here?

MR. OWEN: There will be four of us at the table.

THE COURT: Well, the rest can sit down. We don't need all of these people entering an appearance.

MR. OWEN: These are not all United States.

THE COURT: No. I appreciate that.

Are you antitrust, too?

MS. BRADY: I'm not with the United States. I'm with the state of Florida.

THE COURT: State of Florida? All right. Well, enter an appearance.

MS. BRADY: Lizabeth Brady with the State of Florida, Attorney General's Office.

THE COURT: Great.

MS. LEE: Malinda Lee on behalf of Plaintiff State of California, on behalf of all plaintiff states, which include California, Florida, Mississippi, Washington, and Hawaii.

THE COURT: Welcome.

MR. PITT: Good morning, Your Honor. Jonathan Pitt from Williams & Connolly, representing CVS Health.

THE COURT: Welcome.

MR. COWIE: Good morning, Your Honor. Michael Cowie from Dechert on behalf of CVS Health.

THE COURT: Welcome.

MR. HABASH: Good morning, Your Honor. Rani Habash from Dechert on behalf of CVS Health.

THE COURT: Welcome.

MR. McGINLEY: Good morning, Your Honor. Michael McGinley from Dechert on behalf of CVS Health.

THE COURT: Welcome.

MR. QUILLEN: Good morning, Your Honor. Henry Quillen from Whatley Kallas on behalf of the American Medical Association.

THE COURT: Welcome.

MR. ALLEN: Good morning, Your Honor. Henry Allen for The American Medical Association.

THE COURT: Welcome.

MR. BALTO: Good morning, Your Honor. David Balto on behalf of Consumer Action and the United States Public Interest Research Group.

THE COURT: Welcome.

MR. BARLOW: Good morning, Your Honor. Andre Barlow on behalf of Consumer Action and U.S. PIRG.

THE COURT: Welcome.

MR. ARONICA: Good morning, Judge. Joe Aronica From Duane Morris on behalf of the AIDS Healthcare Foundation.

THE COURT: Welcome.

MR. CASEY: Good morning, Your Honor. Chris Casey

from Duane Morris on behalf of the AIDS Healthcare Foundation.

THE COURT: Welcome.

MR. McCONNELL: Good morning, Your Honor. Sean McConnell from Duane Morris on behalf of the AIDS Healthcare Foundation.

THE COURT: Welcome.

(Pause)

THE COURT: All right, Counsel. We're here to hear the testimony of the first witness, Dr. Sood.

Who will be presenting him?

MR. OWEN: Your Honor, if I may, one preliminary matter for the United States.

THE COURT: You can approach.

Counsel, one counsel for the amici.

(Bench conference)

THE COURT: What's your issue?

MR. OWEN: Your Honor, we appreciate that the Court has already ruled on several evidentiary motions prior to this matter. But in order to reflect the record and note the specific questions --

THE COURT: "In order to reflect the record"? What's that mean?

MR. OWEN: I'm sorry, Your Honor.

In order to keep the record clear --

THE COURT: The record is clear right now.

What's your issue?

MR. OWEN: The United States would like to object to particular questions in certain categories --

THE COURT: There will be no objections. You're not here for that purpose.

Have you got anything else?

MR. OWEN: No, Your Honor.

THE COURT: Thank you.

(Open court)

THE COURT: Dr. Sood, come on up.

He can be sworn.

DEPUTY CLERK: Raise your right hand.

(Witness is placed under oath.)

DEPUTY CLERK: Please be seated.

THE COURT: All right.

Dr. Sood, before you start, you need to understand something: This is not a USC classroom. I went to college many, many years ago, maybe 50. There was no such a thing as slide decks back then.

When I had the *AT&T* trial last year, I learned about slide decks and how they've permeated not only America's universities but corporate boardrooms as well.

Your testimony today will not be by slide deck. We're not going to use any of the slide decks. He's going

to ask you questions --

This is old school. He's going to ask you questions. You're going to give answers to the best of your ability.

And I might have some questions for you. In fact, I'm sure I will have some questions for you. That's the first point.

The second point is, if you have something of this type, which was in your previous filing, that can be used to help explain whatever it is you've got to explain.

But slide decks, no, we don't testify by slide decks, okay?

THE WITNESS: Yes, sir.

THE COURT: All right.

When you're ready to proceed, you may proceed.

MR. QUILLEN: Thank you.

THE COURT: And, by the way, you and both sides can use leading questions. It will help focus his attention. This is not an adversarial proceeding.

I want to remind those in the audience, using electronic equipment will be the grounds for being held in contempt of court, and I'll deal with you directly.

I don't want to have any instance of electronic equipment on, and that includes counsel's table. No cell phones on, no laptops on.

This proceeding is on the record; there is a record of it and there will be a record of it for all to see.

Whenever you're ready.

MR. QUILLEN: Thank you, Your Honor.

And the presentation you were referring to does have a handful of slides of the nature you just described that would be useful for the witness to refer to, so may I bring the --

THE COURT: You can give him that.

MR. QUILLEN: -- presentation?

THE COURT: Does the witness have any water if he needs water? Did you bring him water?

Do you have some water?

Someone will bring it to you. Sit down, Doctor. Relax.

THE WITNESS: Thank you.

THE COURT: And just to look ahead a little bit here, we're going to go to 12:15 for the first segment. He has two hours budgeted, so we probably won't finish him this morning. We'll take a luncheon break, and we'll come back afterwards and we'll hear the rest of his testimony, then the other two witnesses' testimony today.

We will not get to the witnesses for CVS and the Department of Justice that they have -- and Aetna. We will

not get to them today, all right? Just so you have a little overview of where we're going.

MR. QUILLEN: Thank you, Your Honor.

THE COURT: Go right ahead.

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DIRECT EXAMINATION

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NEERAJ SOOD, WITNESS FOR THE AMICUS AMERICAN MEDICAL ASSOCIATION, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

DIRECT EXAMINATION

BY MR. QUILLEN:

Q Dr. Sood, could you give your full name for the record, please, and your academic position?

A My name is Neeraj Sood, and I'm a professor of health policy and economics at the Sol Price School of Public Policy at U.S.C.

Q And what are some of your academic research interests that are most relevant to what we're discussing today?

A Sure.

So I have published more than 100 papers in health policy and economics, and several of those papers are on the Medicare market, as well as on the prescription drug market.

My recent paper on the pharmaceutical supply chain was cited by the Council of Economic Advisers.

I am on the editorial board or associate editor and co-editor of several journals in my field, such as the Journal of Health Economics, Journal of Policy Analysis and Management and Health Services Research.

I'm also a research associate at NBER, which is a premier economic research organization.

Q Broadly speaking, what subjects do you intend to testify about today?

A So I want to answer one key question in today's testimony, which is that: Did the divestiture of Aetna's PDP, or prescription drug plan, assets to WellCare, will that divestiture restore competition to the pre-merger levels?

And once I've answered that question, I also want to comment on some of the claimed efficiencies of this transaction which were in the proposed testimony of other witnesses.

Q Can you describe what a PDP is.

A Sure.

So a PDP, or a prescription drug plan, is a standalone plan that only covers prescription drugs, and it is offered to people who are eligible for Medicare. So this is part of the Medicare Part D program.

And so unlike typical insurance where -- which would cover your hospital bills, your doctor bills, and your

drugs, a PDP only covers drugs and only people in Medicare are eligible for it.

Q In your opinion, what are some of the key features of the PDP market as it relates to the issues in this case?

A So I think there are four key features of the PDP market that are relevant for this case.

So the first thing, as I said, is, if you are eligible for Medicare, then you are in the PDP market. So the consumers here are the elderly. And the elderly typically, since they're retired, have lower incomes, have multiple health conditions.

So any potential harm in this market because of this transaction is going to be borne by this one area of the population.

The second important feature that we should remember is that since the PDP market is part of Medicare, Medicare or the government actually subsidizes PDP premiums, and also subsidizes certain expenditures if beneficiaries exceed certain expenditures.

So if they have more than, say, $5,000 in expenditures on drugs, then the government kicks in and pays for those drugs rather than the prescription drug plan. So what happens is, as a result of these subsidies, there is a bunch of regulations that plans need to abide by.

And this has two consequences for this market on

how we think about this transaction. The first is that any increase in market power as a result of this transaction would mean higher cost of subsidizing PDP coverage for the government.

And the second, given the subsidies in the regulation, those create barriers to entry into this market. So you just can't -- you know, it's not like opening a shop. You have to plan much in advance. You have to have the capability of understanding all the government regulations and abiding by them if you want to enter this market.

THE COURT: Now, hold on a second.

You made reference to prescription drug plans.

THE WITNESS: Yes.

THE COURT: Those are separate from the PDP, right?

THE WITNESS: No. So prescription drug plan is the same as PDP.

THE COURT: So how about people who are not on -- Medicare eligible, do they have prescription drug plans?

THE WITNESS: So people who are not Medicare eligible don't have prescription drug plans, so they would either buy insurance on the health insurance exchanges, which would be both covering your hospital and doctor visits, as well as prescription drugs.

So PDP is only relevant to plans which are

prescription drug only and only Medicare population is eligible for them.

THE COURT: Okay.

BY MR. QUILLEN:

Q How would you describe the role of CVS and Aetna in the prescription drug plan market before the merger?

A Sure.

So the other feature of the PDP market that is important is that the concentration in the PDP market has been increasing over time. So this transaction is happening in a market where prior mergers have already led to a significant increase in market concentration.

And as you asked me that: What is the role of Aetna and CVS in this market?

So Aetna and CVS both participate in the PDP market. The PDP market is divided into 34 regions. Each region is either a state or a group of states. And Aetna and CVS, as well as WellCare, participate in all 34 PDP geographic markets or regions.

And so what'll happen as a result of this transaction is, we're going to lose Aetna as a competitor from this market; that Aetna will no longer participate in this market.

And this is significant for two reasons; first, Aetna has been a very strong competitor in this market, so

their market share, from 2009 to 2018, increased from about 2 percent to 9 percent. So that's a fourfold increase in market share. So we are not only losing a competitor, we are losing a strong competitor from this market.

And the second thing is that the DOJ has acknowledged that Aetna and CVS provide significant head-to-head competition with each other, which means that now, post this merger, that head-to-head competition would be lost, which would be a loss for consumers.

BY MR. QUILLEN:

Q Can you say more about the population that the PDP market serves?

A Sure.

So there are about 25 million people enrolled in the PDP market. 21 million of those are over the age of 65. The rest are eligible for Medicaid, not through their age but through disability or some other way.

Out of these 21 million people who are above the age of 65, 10 million are actually above 75 years or older. So this is a population with very advanced age.

29 percent of the population is eligible for something called the low-income subsidy. So you become eligible for the low-income subsidy if your income is below a certain threshold, which is about 150 percent of the federal poverty line, or you qualify for other low-income

benefits such as the Medicaid program or the Supplemental Security Income. So 29 percent of this population actually qualifies for the low-income subsidy.

And even the remaining population is not very well to do. These are retired folks. They're not, they don't have -- they're not working right now, so they don't have a source of income.

About 68 percent of not the PDP population but Medicare beneficiaries in general suffer from multiple chronic conditions or multiple conditions. So they have hypertension and diabetes or -- you know, at least two conditions.

And within this population, the majority have four or more health conditions simultaneously. So this is a population in poor health, who are potentially low income, of advanced age.

So any increase in market power that results in an increase in premiums will be borne by this population, and I think that is important to kind of keep in mind as we think about this transaction.

THE COURT: How much of that market, 25 million in that market, prior to the mergers being covered by Aetna?

THE WITNESS: 9 percent.

THE COURT: 9 percent?

And what percent was being covered by CVS?

THE WITNESS: I think 24 percent.

THE COURT: All right. Thank you.

BY MR. QUILLEN:

Q You mentioned that PDP markets are subsidized. Can you talk more about the subsidy and how the costs break down between the government and the enrollees?

A Sure.

So what happens in the PDP market is plans are required to submit bids to the government on what they think their total costs or premiums would be.

And what the government does is, takes all those bids, calculates an average, and says that the government will pay 75 percent of the average, and beneficiaries are responsible for the remaining part of the premium. So the level of subsidy for an average plan is about 75 percent.

In addition, if you are low income or you qualify for the low-income subsidy, then the government subsidizes premiums even more.

In fact, in each PDP region, there is a plan that if you qualify for the low-income subsidy, your premiums as a consumer would be zero.

And the third way the government subsidizes the PDP plans is that if a beneficiary's expenditures exceed what they call or are in the catastrophic zone, so they exceed a certain threshold, that instead of the plan, now

the government starts paying healthcare costs or prescription drug costs for these consumers. So those are three ways that the government subsidizes PDPs.

And any increase in market power in the PDP market would mean higher costs of subsidizing those premiums or those PDP market for the government.

Q You mentioned that there are 34 geographic markets for PDPs. Are the same plans offered in each market?

A Yes.

So there are 34 regions, and each region has a uniform choice of plans.

So basically if I am in a given region, anyone in a given region will have exactly the same choice of plans within that region.

And that choice, that varies across regions. So plans are deciding what, like their bids are going to be and then in which of these 34 markets they want to operate.

THE COURT: Let me ask you to stop there.

THE WITNESS: Yes, sir.

THE COURT: Now, who makes those decisions? Are those the PBMs?

THE WITNESS: No.

So the decision to operate in which market is made by the health plan and not by the -- as far as I understand, not by the PBM.

The PBM's role is to help the health plan with benefit design, with negotiating with pharmacies.

THE COURT: For the cost of the individual drugs?

THE WITNESS: Yes.

And also negotiating with manufacturers for the cost of the drugs.

THE COURT: Okay.

THE WITNESS: So what they're basically saying is they design the health benefits or they decide how much cost sharing or co-pays or co-insurance there will be for a given drug in a given plan.

Then they decide for that given drug how much reimbursement the plan will give to the pharmacy if someone from the plan uses the drug.

And they also go to the manufacturer and say, Hey, people in my plan are using this drug, you need to give me a rebate, you need to give me a discount, which they will pass on some of the discount back with the plan, and some of the discount they might keep for themselves.

THE COURT: So they're setting prices that apply not only to people under the PDP program, which is the Medicare eligible, but the non-PDP people, right?

THE WITNESS: So PBMs operate in the non-PDP market also.

THE COURT: That's right.

THE WITNESS: Yeah.

So they are setting -- in that sense, yeah, they are setting.

So what -- technically, the prices are -- for drugs are set by the pharmaceutical company. So there's something called the list price of the drug, which is set by the pharmaceutical company.

But then the PBM goes to the pharmaceutical company and negotiates a rebate. And so the net price of the drug is, in some sense, set by the PBM because the net -- what the pharmaceutical firm gets is not the list price but the list price less all rebates and concessions they have offered either to the PBM. And sometimes they offer concessions directly to consumers or to pharmacies.

THE COURT: And there's three PBMs that dominate the role of PBM nationwide, correct?

THE WITNESS: Yes, sir.

THE COURT: They have 70, 75 percent of the market?

THE WITNESS: About 70 percent of the market.

THE COURT: About 70 percent of the market.

And CVS is the largest of the three?

THE WITNESS: Yes, sir.

THE COURT: So they're setting the prices -- Aetna will now be using CVS's PBM for this purpose, correct?

THE WITNESS: So, yes, Aetna already has, so prior to the merger had an agreement with CVS to provide certain PBM services to Aetna. And -- but Aetna also said that they retained some of the PBM functions themselves.

So part of the services were being provided by CVS and part were being provided by Aetna.

And it is my understanding that post this merger, everything is within the same firm; so in some sense, everything is being provided by CVS.

BY MR. QUILLEN:

Q And so to sum up, would it be fair to say that the prices that the PBM passes on to a PDP are a major input in the PDP's premiums?

A Yes.

So the PBM is a major provider of input.

So if you're thinking about establishing a prescription drug plan, a lot of key functions are being performed by the PBM.

So like to take a car example. It would be like the engine is what the PBM is providing or the servicing of the car is what the PBM is providing, because they are the ones who are negotiating key contracts with manufacturers and pharmacies. They're the ones who are deciding on benefit design. So they -- and they also process claims. So they play a major role.

Q And the three PBMs that account for 70 percent of the industry, do they all -- are they all part of companies that offer PDPs?

A Yes.

So the three big PBMs are CVS; Express Scripts, which owns Cigna; and Optum, which owns -- or Optum, which is owned by United. And all of them are payers in the PDP market.

Q So would it be accurate to say that WellCare now, after the merger and divestiture, is a customer of CVS but also a competitor of CVS and the corporations associated with the other PBMs as well?

A Yes, that would be accurate.

So currently, CVS is the PBM for WellCare. So CVS is providing these key inputs of PBM services to WellCare.

At the same time, CVS has its own PDP plans that compete with WellCare.

So this would be, again, like to take the car example, if Mercedes and Tesla were competing with each other in the electric car market and the Mercedes electric car actually had Tesla batteries or the Tesla electric system, it's something similar to that.

Q Did that actually happen?

A That actually did happen in 2014.

But those cars were discontinued roughly two years

later because, I think -- and now Mercedes is planning to make its own batteries and its own electric system.

Q Since we're on the topic of PBMs, let's stay with it.

Can you say a little bit more about the functions that a PBM provides for a PDP?

A So a PBM provides a variety of functions for the PDP.

So the first function would be helping with a benefit design of the PDP.

And the second function is helping negotiate rebates with pharmaceutical manufacturers.

The third function would be helping negotiate reimbursement to pharmacies.

And the fourth function would be processing claims and also providing customer service.

So, for example, if on my U.S.C. plan, if I have a problem with a prescription drug claim, I'll probably call a 1-800 number of the PBM, who will provide me service.

Q As the supplier of PBM services to WellCare, do you think that CVS would have the same incentive to provide the same level of service and pricing to WellCare as it does to Aetna?

A It would not, because if you think about just the incentives, if they provide excellent service to WellCare,

that makes WellCare a stronger plan. And that means WellCare is going to take market share away from CVS because it's competing with CVS in the same market. And which means CVS will lose because they are providing better service to WellCare.

So they have an incentive to provide better service to themselves than to rival plans, because, again, providing better service to your own plan will make your own plan stronger, which would then take market share away from WellCare and other rivals in the PDP market.

So the incentives are aligned to kind of provide better care to yourself, rather than to a competing plan like WellCare.

THE COURT: And how does CVS's having the Aetna customer base -- it's 21 million people in the customer base of Aetna?

THE WITNESS: About 2.2 million people.

THE COURT: 2.2 million.

How does that assist or strengthen CVS's PBM ability vis-à-vis the other PBM companies?

MR. QUILLEN: If I may, I think we may be talking about the PDP Aetna enrollees, who were about 2.2 million.

The overall Aetna enrollees in all its products are the higher number, the 20-something million.

THE COURT: Right.

So by virtue of the merger, right --

THE WITNESS: Uh-huh.

THE COURT: -- CVS's PBM entity, which is in the top three already --

THE WITNESS: Yes.

THE COURT: -- right, will have the advantage, I will assume -- correct me if I am wrong -- of now being able to represent to the manufacturers, you know: I represent this large group of people who are either in the PDP plan or the non-PDP plan, but they're healthcare-covered.

Wouldn't that strengthen their PBM business, vis-à-vis the other PBM company?

THE WITNESS: It would.

The only caveat I would say is that prior to the merger, Aetna already had an agreement with CVS to provide some PBM services.

THE COURT: Okay.

THE WITNESS: But you're right that to the extent that that agreement is now being strengthened because you cannot -- so an agreement can be annulled or can be changed or not renewed when a contract is up.

So this merger definitely strengthens that position, because now you're not like, well, you're providing some PBM services to 22 million customers. They

are our customers.

So in that sense, it would strengthen CVS.

THE COURT: All right.

BY MR. QUILLEN:

Q And you said CVS wouldn't have the incentive, the same incentive to provide excellent service to WellCare as it would to Aetna. Does that same logic apply to passing through the rebates that CVS receives from the manufacturers?

A Yes.

So the same logic would apply that if I pass on more of the rebate dollars that I'm getting from the manufacturer to WellCare, that allows WellCare to lower its cost and lower its premiums and, again, compete with CVS in the PDP market and take away some of their market share.

So the same logic would apply for any of the things that PBM, any of the services that PBM is providing to WellCare.

BY MR. QUILLEN:

Q Would that include CVS's negotiations with pharmacies as well?

A Yes.

And I think there, it gets even more complicated, because CVS, the PBM --

THE COURT: Right.

THE WITNESS: -- is negotiating with CVS, the pharmacy, for WellCare or for a rival plan, and you can only manage imagine how those negotiations might happen.

So now it's, you know, just to complete this thing, that if you negotiate hard with CVS, the pharmacy, CVS, the pharmacy, loses money; but that benefits WellCare because their costs are lower.

And now since and because it benefits WellCare and they can lower their premiums, they can take away market share from CVS, the health plan and the PDP market.

So you might lose money now two different ways, one by lowering your margins on the pharmacy business and the other by losing market share in the PDP business.

BY MR. OWEN:

Q Well, if WellCare feels like it's getting a raw deal from CVS, can't it just go elsewhere?

A It could potentially go elsewhere.

So I think there are multiple conditions.

First, it has to know that it is getting a raw deal or somewhat of a raw deal.

And the PBM market is known for being opaque. So it's very difficult to figure out, even as a health plan, what your PBM is actually doing. What discounts had -- did it get from the different entities? How many of those discounts are being passed back to the health plan? Or, you

know, what is the level of customer service that they are providing?

So there might be subtle ways in which they disadvantage a health plan, and the health plan might not be able to figure out what's happening.

So the first thing is the probability of detecting what economists call this phenomena input foreclosure is low.

The second thing is, suppose you even detect input foreclosure and you find that CVS is not providing you the service that you expect. What are your options? You will go to some other PBM provider.

But the other two PBMs, Express Scripts and Optum, are also owned by health plans that are competing with you. So you will face the same conflict with those other PBMs that you would face with CVS as your PBM.

And as -- Your Honor, as you had mentioned earlier, that the PBM market is fairly concentrated. The top three PBMs account for 70 percent of the market. So you don't have a lot of good outside options beyond the top three.

And we know that if you go to a smaller PBM, then they don't have that same negotiating power. You cannot go to a PBM that controls 1 million lives and expect big discounts from manufacturers or pharmacies.

THE COURT: Let me make sure I understand something here.

THE WITNESS: Yes, sir.

THE COURT: The PBMs when they're competing with one another, do I understand correctly, they're competing to get the contractual relationship with the health plan providers?

THE WITNESS: Yes. Yes, sir.

THE COURT: So when they're competing to get a contract to represent the health plan providers, I'm trying to figure out exactly what they're bringing to the table.

Would it be accurate to say what they bring to the table is the network of pharmacies?

There's 70,000 pharmacies in the United States, as I understand it, roughly.

THE WITNESS: Uh-huh.

THE COURT: CVS has 7900 of those 70,000.

THE WITNESS: Uh-huh.

THE COURT: So I would imagine that CVS PBM, when it's trying to get a contract, is emphasizing, look, we've got this network of 7900 pharmacies nationwide. And now with Aetna, they can say, Well, we have 21 million customers, both PDP and non-PDP, who are getting services from us.

So that's -- and then we have a such-and-such a

track record from negotiating good deals for rebates.

THE WITNESS: Yes.

THE COURT: Are those the kinds of things that they're putting up as incentives for these health plans to hire them?

THE WITNESS: Yes.

So when a health plan is thinking of hiring a PBM, what the health plan should care about is, what is the total cost of providing the prescription drug benefit?

And as you said, there are two ways to better save money on these total costs. So when you network or when you contract with all these 70,000 pharmacies, you're not only saying that we have a relationship with them, but we've negotiated a low level of reimbursement with them, and that -- we're going to pass on some of those savings back to you as a health plan.

And, similarly, what they're saying is that, look, we represent 90 million people. So with 90 million people, when we go negotiate with the pharmaceutical manufacturer, we're going to get a big rebate and we're going to pass on those rebate dollars back to you.

So those are the, you could say, like two primary ways in which a PBM can help a health plan lower their costs.

THE COURT: Okay.

BY MR. OWEN:

Q In a market like the PBM market where three firms control 70 percent of the business, I mean, would you expect, as an economist, that if WellCare leaves CVS, it's going to get the same sort of pricing from Optum or Express Scripts that it would in a highly competitive market?

A No.

So, again, and as I said, the prices are correlated with market concentration. So the higher the market concentration, the higher will be the prices.

And as I said, that it's not just the high market concentration, but also the fact that the other top-two PBMs are owned by health plans themselves, which are competing with WellCare.

So by going to these other two top PBMs, you really haven't solved the problem of input foreclosure. They will still -- Optum would have the same incentives to not provide the same quality service to WellCare as it provides to its own UnitedHealth plans which are competing with WellCare.

So by going to these two other top PBMs, you really haven't solved the problem.

Q Even if CVS were to lose WellCare as a customer because the pricing or the service were just not as good as

WellCare wanted, could that still be a profitable strategy for CVS?

A It could be.

So let's think about the economics of it or how the math would work out.

So suppose you're CVS and you know that if you provide poor service to WellCare, there is some probability that you will lose WellCare as a customer, and so why -- basically, that probability times the profit per customer is what you will lose.

So in the PBM industry, the net margins are about in the 2 percent range.

So if a customer is spending $100 on a prescription drug, just hypothetically, and you lose that customer as a PBM customer, you're going to lose $2.

If, now, as a result of doing this input foreclosure, you could also gain a customer for the CVS PDP and if you gain a customer for the CVS PDP, you provide PBM services to this customer, so you're going to get your $2 back; and, in addition, you're going to make a profit on the PDP side of the market. So that's roughly another $3.

And in addition, if the customer goes to a CVS/Pharmacy, you're going to make a profit on the pharmacy side of the market. That's an additional $3.

So what'll happen is that losing one PBM customer

is roughly $2, but gaining that same customer back as a pharmacy PBM and health plan customer is roughly $9 extra in profit.

So each integrated customer is roughly four times as profitable as just a PBM customer.

THE COURT: I have a question about that analysis you just went through.

THE WITNESS: Yes, sir.

THE COURT: I recall in your materials, Doctor, that breakdown that you just alluded to of the $100 -- for every $100 of -- spent for -- by an insured customer, you did a breakdown that had 58 of the 100 going to the manufacturer and 42 going to the middlemen --

THE WITNESS: Yes.

THE COURT: -- right?

The PBM got $5, in your breakdown?

THE WITNESS: Yes.

THE COURT: The pharmacy got 15 out of the 100?

THE WITNESS: Yes.

THE COURT: The wholesaler got $2?

THE WITNESS: Yes.

THE COURT: But the thing that caught my eye the most was the insurer was getting 19?

THE WITNESS: Yes.

THE COURT: That confused me, and I want you to

help me clear that up in my mind.

The insurer, the person -- remember now, this is $100 spent by an insured customer?

THE WITNESS: Yes.

THE COURT: The insurer is already paying monthly for his health insurance plan or her health insurance plan, right?

THE WITNESS: Uh-huh.

THE COURT: So how is the 19 -- they've already paid that. How can another $19 be going to the insurer when they've already been paid the monthly fee?

THE WITNESS: So basically what that estimate is that, suppose I pay my $100 in premiums to an insurer.

And if I look at the financial statements of insurers, what they say is they spend roughly $81 out of those $100 on reimbursing my healthcare expenditures, and the remaining $19 they keep either as profit or administrative costs or marketing expenses.

So that $19 reflects basically the fraction of the premium that is not going towards healthcare but is going towards some other insurer function.

THE COURT: So when you say $100 spent by an insured customer on pharmaceutical products, you're not talking about the $100 they spent at the pharmacy itself?

THE WITNESS: No. Yeah.

THE COURT: No.

It's a more --

THE WITNESS: Holistic.

THE COURT: -- more holistic approach.

THE WITNESS: Holistic, exactly.

THE COURT: Thank you for clarifying that.

BY MR. QUILLEN:

Q And in your opinion, does CVS have the ability to use its pharmacy network to disadvantage its competitors if it wanted to?

A Yes, I do.

So CVS's own financial statements say that among the top 100 pharmacy markets in the U.S., they are the No. 1 or No. 2 company in 93 out of those top 100 markets. So they're saying we're No. 1 or No. 2 in 93 out of the top 100 markets.

So now, if you are -- you know, if you think about the incentives of CVS, pharmacy, they could basically say, we're not going to provide competitive rates to health plans in these markets, and these health plans will not have much option, because CVS is a dominant or the No. 1 or No. 2 pharmacy in these markets so --

THE COURT: So this is what the PBM would be saying, CVS PBM?

THE WITNESS: Yes, CVS PBM or CVS/Pharmacy itself.

THE COURT: Okay.

THE WITNESS: So CVS/Pharmacy would say: We're not giving a big discount to a health plan that's competing with CVS.

So like when -- and you're right that there will be a PBM on part of the health plan that will be negotiating with CVS the pharmacy.

But basically the CVS/Pharmacy has less of an incentive to give a price discount to a competing health plan versus to its own health plan, because if they give a price discount to a competing health plan, that takes away market share from the CVS health plan.

And if they are the No. 1 or No. 2 pharmacy in that market, they're kind of like a must-have pharmacy. So a competing health plan will just have to accept the higher rate, rather than say, I'm not dealing with CVS, I'm going to contract with other pharmacies.

But in markets where CVS is not the No. 1 or No. 2, then that incentive is not there because you can always say there are -- there's enough competition there to contract with other pharmacies.

BY MR. QUILLEN:

Q And in your opinion, if the net price to the plan of prescription drugs went up, all things being equal, would premiums go up, too?

A Yes.

So as prices go up, premiums would go up, because premiums are used to cover healthcare expenditures. So if that underlying cost is going up, your premiums are going to go up.

Q I'd like to talk about something you mentioned earlier: The increasing concentration in the PDP market. Can you say a little bit more about that, please?

A Sure.

So analysis done by Professor Richard Scheffler, using publicly available data on PDP enrollment in these 34 different geographic markets, shows that from 2009 to 2018, the Herfindahl Index increases by 342 points, or 23 percent.

Q And can you say what is -- what is the Herfindahl Index and why is it important here?

A Yeah. Sure.

THE COURT: Yeah. We don't deal with that every day around here.

THE WITNESS: The Herfindahl Index is a well-known and the most commonly used measure of market concentration.

And economists typically believe that the higher the Herfindahl Index, the higher the prices would be in the market.

And the DOJ/FTC have guidelines which are based on

the Herfindahl Index on whether they think the market is moderately concentrated or highly concentrated.

THE COURT: And the -- correct me if I'm wrong now:

Now, the importance of that analysis with regard to the higher the prices is that in order to determine the public interest in any transaction going forward, the Department of Justice and the Courts, ultimately, have got to decide whether or not it's likely to cause prices to go up or down.

THE WITNESS: Yes, sir.

THE COURT: Because if they're likely to go up, it's not going to be in the public interest. And if it's going to be less available, it's not going to be in the public interest.

So both Justice and the Courts are trying to figure out price -- I mean, the likely consequences to the pricing of the product, right?

THE WITNESS: Yes.

So basically what the -- you're absolutely right.

And basically what the publicly available enrollment data shows, that not only did the Herfindahl Index go up by 342 points over this period, which is substantial -- so, for example, the DOJ/FTC guidelines consider a 100-unit increase in the Herfindahl Index that

leads to a moderately concentrated market as raising significant competitive concerns.

MR. QUILLEN: And there's a demonstrative slide -- if the Court would like to look at it, No. 17 --

THE COURT: 17.

MR. QUILLEN: -- that lays out the various categories from the DOJ and FTC guidelines that are used in horizontal merger cases to determine what level of concern one should have about increased concentration in a market.

THE COURT: That is -- now, does counsel have a copy of these, opposing counsel?

MR. QUILLEN: Yes.

THE COURT: Okay.

All right. I have 17 here.

MR. QUILLEN: Okay.

THE WITNESS: So basically, slide 17 shows how the DOJ/FTC guidelines treat changes in Herfindahl Index and post-merger Herfindahl Index.

So if the Herfindahl Index is less than 1500 and the change in the Herfindahl Index as a result of a merger is less than 100, then there's no challenge or no concern.

If the change in the Herfindahl Index is greater than 100 and the Herfindahl index after a merger is between 1500 and 2500, then that raises significant competitive concerns.

If the Herfindahl Index is between -- the change in index is between 100 and 200, and after the merger the market becomes highly concentrated, which is the Herfindahl Index exceeds 2500, again, there is significant competitive concern.

And the -- kind of the most severe case is where the Herfindahl Index increases by 200 and the market is highly concentrated as a result of the merger. So post-merger, the Herfindahl Index is greater than 2500.

In that case, the guidelines say that the merger is presumed likely to enhance market power. And it can only be or it should be -- it could be reverted by evidence that maybe, say, entry in the market or some other thing would reduce the Herfindahl Index.

THE COURT: Okay.

THE WITNESS: So going back to kind of the trends in the Herfindahl Index, Herfindahl Index in each one, on average, increase by 342 points. So you can see much higher than the FTC DOJ threshold.

And in 2018, all markets were moderately concentrated, which means their Herfindahl Index exceeded 1500. And there were two markets which were highly concentrated, which means their Herfindahl Index exceeded 2500.

So this transaction is happening in a market that

is experiencing significant increases in Herfindahl Index already, and that already is either moderately concentrated or highly concentrated.

There's a paper by Princeton researcher Anna Charney. And what she and her colleagues did is, they looked at data from 2006 to 2012. And what they find is that in every year from 2006 to 2012, roughly 15 percent of the plans in the PDP market were involved in a merger.

In fact, they say that during this time period, nearly every major PDP insurer has been involved in a merger.

So one of the reasons why the Herfindahl Index has been increasing over time is because of mergers in these markets.

The other thing they say is during the same time period, 2006 to 2012, there was basically no entry of health plans after the first two periods.

So after 2006 and 2007, they find little or no entry of health plans in these markets.

So there are mergers happening. There is no entry happening.

And what they find is that during the same time period, premiums increased by 41 percent in nominal terms, and about 26 percent inflation adjusted.

They also find that drug coverage fell down by

about 29 percent.

And out-of-pocket costs for consumers for the most popular drugs doubled.

So you basically have a market with rising concentration during this time period, mergers, no entry, high premiums, and declining coverage or higher out-of-pocket costs for customers.

And if you look at what the evidence says on the effects of mergers in these markets or the effect of concentration in these markets, there are three studies that have directly looked at the effects of competition or mergers in the PDP market.

The first paper is by the Congressional Budget Office. They have a working paper where what they did was they compared markets where the number of competitors was changing over time, relative to markets where the number of competitors was not changing over time.

And what they find is that markets in which the number of competitors or forms is changing over time, those markets have lower premium growth, compared to markets where the number of competitors is constant.

So basically what they say is increase in the number of firms in the market leads to lower premiums.

So a merger will reduce the number of firms in the market and, therefore, will lead to higher premiums.

There's another study by the Princeton researchers, the same study I mentioned earlier. What they do is they explicitly look at mergers in these markets.

So the third experiment is compare two plans which are operating in the same market. One plan merges and the other plan, which is operating in the same market, doesn't merge.

The plan that merges, it sees a premium growth -- a premium change over time 7 percent more than the plan that does not merge.

So they're basically saying, Look, when plans merge, that leads to about a 7 percent increase in premiums as a result of the merger, because any other thing that's happening in this market is controlled for by looking at premium trends for these plans that did not merge and that were exactly in the same market.

A third approach is a paper by Wharton Professor Claudio Lucarelli, and he took a different approach. So he took what economists call a structural approach.

So what he did is he says, I'm going to come up with a model of how consumers behave in this market, how they choose plans, what plan features matter most to consumers.

Then I'm also going to create a model of how firms behave in this market and compete with each other.

And then I'm going to use existing data from the market, the market share of firms, the features of different plans, to calibrate this model, to calibrate how consumers and firms actually behave or to find out what the parameters of these models are.

And once you have done that, you can now run what-if scenarios. So you can say, What would happen if Firm A merged with Firm B in this market?

And that's what they did.

So they looked at the merger of two companies in this market, and that predicted that premiums of the merged firms would go up by 4.7 percent.

And actually, premiums of firms that do not merge, they also go up by roughly 1 percent or 0.9 percent. The reasoning is that now they know the market is more concentrated, and that results even rival firms to increase their prices.

So in some sense, all three studies reach the same conclusion, even though they take very different approaches.

One approach is at the market level. The other is at the plan level. The third one is the structural model. All three of them reach the same conclusion, which is that mergers lead to an increase in concentration and lead to higher premiums.

And as you had mentioned earlier, what happens to

premiums is a key question for public interest.

So all three studies which have looked at the PDP market have the same qualitative conclusion: That loss of competition in the market or mergers in these markets lead to increases in premiums.

BY MR. QUILLEN:

Q Are you aware of any studies as reputable or widely cited as these that come to the opposite conclusion?

A I'm not.

These are the only three studies I'm aware on the PDP market.

Q And how do the results of the empirical analyses in these papers compare to what you would expect as a theoretical matter as an economist?

A So the empirical evidence from these three papers is consistent with economic theory.

So, again, there are different -- these papers have used different approaches to theoretically model this market.

So you can use option theory, where firms are -- that's where they're trying to mimmick the institutional details of this market, where firms submit bids and then the plan with the lowest bid will attract more customers.

You can use traditional model like the Bertrand model, where firms are competing on prices; or another

traditional model called the Cournot model, where firms are competing on quantity.

But, ultimately, it doesn't matter what model you use. All three models predict the same thing: That the loss of a competitor from a market will result in higher premiums.

And the merger and divestiture does result in a loss of competitor. So Aetna will no longer be in the market, whether the divestiture happens or not, because Aetna is out of the market, irrespective of the divestiture happened.

So, basically, all three theoretical models would also predict that this merger and divestiture together will raise premiums.

Q I understand that you've done some calculations of the concentration in the market after the divestiture under some various assumptions about how much of Aetna's former business WellCare could keep.

And I think slide 18 will actually be useful to look at for purposes of this discussion.

A Actually --

Q Can you explain slide 18 there?

A Sure.

If I have the permission, I would like to start with slide 16 --

Q Sure.

A -- because -- and I apologize for the math, but I think that's --

THE COURT: Well, that's your line of business.

THE WITNESS: That will help explain slide 18 better.

So what this does is you're calculating this Herfindahl Index, that is, this measure of market concentration.

And pre-merger, I'm treating Aetna, CVS, and WellCare as separate entities. So the three of them are competing with each other in these markets.

So, in fact, in all 34 markets, Aetna, CVS, and WellCare pre-merger were competing with each other.

Post-merger and divestiture, what'll happen is some of Aetna's consumers will be assigned to WellCare, right? Because we've sold Aetna's PDP business now to WellCare.

But not all of these consumers are going to stay with WellCare. The next open enrollment, some of them might move back to CVS.

So the fraction of Aetna's consumers that CVS can control is what I call the retention rate, and that is going to determine how the Herfindahl Index changes in this market.

So now, if you go to slide 18.

So this shows how this mathematical formula works in the Kansas market.

So let's start with the assumption that WellCare has the ability to retain 100 percent of Aetna's consumers with itself. So none of these consumers go back in the next open enrollment to CVS.

In that scenario, if you look at the bottom right-hand corner, the Herfindahl Index would increase by 95 points, and the post-merger divestiture Herfindahl Index would be 2,140.

So since 95 is just below that 100 threshold, there's no significant concern.

But if I relax the assumption of 100 percent retention just a little bit, so now I say only 90 percent of Aetna's consumers will stick with WellCare but 10 percent will move back to CVS.

So even under the assumption that only 10 percent of WellCare's -- of Aetna's consumers move back to CVS, now the Herfindahl Index rises by 120 points.

And the post-merger or post-divestiture Herfindahl Index is 2,165.

So according to the DOJ/FTC guidelines, that would be significant competitive concerns.

And so if you imagine that WellCare is not a

strong plan, cannot compete aggressively with CVS, then you might have scenarios where WellCare is able to retain, say, only 50 percent of the consumers.

So if that happens, if you look at 50 percent, the Herfindahl Index rises by 282 points. So that is significantly above the 100 threshold. And the market is approaching becoming highly concentrated. The Herfindahl Index post divestiture is 2,327.

And, finally, if you take the last two scenarios, which is, suppose WellCare can only retain 20 percent of Aetna's consumers. In that scenario, the Herfindahl Index rises by 468 points. So way above the 100 or 200 threshold in the DOJ/FTC guidelines, and the market now becomes highly concentrated.

So this is a scenario where there's a presumption of increase in market power.

And the same holds for the 10 percent scenario and the zero percent scenario.

So what this shows is what other prediction is about how strongly can WellCare compete with CVS and how many of these customers can they actually retain versus how many of them will be lost is critical in understanding what will happen to the Herfindahl Index and, in that sense, in understanding whether this transaction is in the public interest or what will happen to premiums and will this

transaction raise significant competitive concerns.

So if you go to the exhibit on slide 19, what I did was I repeated the analysis I did for Kansas for all markets, all 34 markets.

So the first row here shows what I think is the best-case scenario, which is that after the divestiture, Aetna consumers go to WellCare. Somehow, they love WellCare and they don't ever want to leave it. And so WellCare is able to retain 100 percent of these Aetna consumers.

Even in that scenario, there are 7 out of those 34 markets where there would be significant competitive concerns.

So now let's relax this assumption a little bit. So let's say, no, maybe some -- these were consumers who chose Aetna plans, right? Like they had a choice to chose between WellCare and Aetna, but they chose to go with an Aetna plan. So now when they find out that they're actually no longer in an Aetna plan, they actually belong to WellCare, some of them would want to move back.

So let's assume 25 percent of them move back.

THE COURT: That's -- a typical contract is, what, two years or one year?

THE WITNESS: One year.

THE COURT: One year.

THE WITNESS: One year.

BY MR. QUILLEN:

Q And can you say something about the branding of those plans now and over the next couple of years?

A Yes.

So my understanding is that for the first year, for 2019, WellCare can use Aetna's brand.

So for the first year, maybe consumers don't know. They think -- they still think they're in Aetna.

In the next year, they cannot use the brand, so they'll have to tell the consumers: You are in WellCare. So some of them might want to move to CVS.

But in the next year, CVS cannot use the Aetna brand but people would still know that CVS and Aetna have merged.

And the year after that, they can reintroduce the Aetna brand.

So then you can have even a greater exodus of people who like Aetna wanting to move back to an Aetna brand, right?

So I think the scenario where, say, I think it's still optimistic that 75 percent of the customers still remain with WellCare, but 25 percent decide to move to CVS or Aetna combined.

And in that scenario, what happens is that the number of markets with competitive concerns triples. So

instead of seven markets where there are significant competitive concerns, now we have 21 markets with significant competitive concerns and one market where there is actually a presumption of increase in market power.

And now if you take the scenario further, so now we say, let's do it 50/50, I don't know, 50 percent is a good number.

So Aetna retains 50 -- or WellCare retains 50 percent of Aetna's consumers, but 50 percent decide to go back to CVS. In that scenario, 30 out of the 34 markets have significant competitive concerns, and one market has a presumption of increase in market power.

So, again, this analysis shows that the key factor or one of the key factors in helping figure out whether this divestiture raises significant competitive concerns is to understand WellCare's ability to hold on -- to compete with CVS and Aetna and to hold on to these Aetna customers that were divested to them.

THE COURT: And who's WellCare using, in this first year anyway, as its PBM manager?

THE WITNESS: It is CVS.

So -- and that is a very good question, which leads to their ability to compete with CVS.

If one of the key inputs that are -- to you, are being provided by your competitor, your ability to compete

with CVS would be limited.

Another factor which I think -- which says that they will not be able to retain a lot of these customers, is if you look at the price at which WellCare bought Aetna's PDP assets.

So let's start with the original transaction. CVS bought Aetna for $69 billion. Aetna's profits are, I think, in the 4.2 or $4.6 billion range. So they bought Aetna for 16 times their profits per year.

And so you would ask: Why are you buying someone for 16 times profits per year? Because now you own the company. You're not only going to enjoy these profits one year, you're going to enjoy these profits every year from so on.

So if you take the present value of all the future profit stream, it seems reasonable to pay 16 times profit, right?

So now WellCare bought Aetna's PDP assets, according to their financial statements, for about $107 million.

So if you take the same multiple of 16, this translates that WellCare expects profits from Aetna's PDP business to be in the 6 million or $6.7 million range.

So you would ask, like -- so remember, we noted that Aetna has 2.2 million PDP subscribers. So you're

basically saying, 2.2 million PDP subscribers are only going to generate 6.7 million in profit. That's $3 of profits per consumers. That is way too low.

So I think the reason they bought it at such a low price is because they know they wouldn't be able to retain these profits -- these customers.

So they know that all the 2.2 million customers are not going to be generating profit for them year after year, and that's -- because otherwise, another way to look at this is, say these 2.2 million customers on average, they spend about $2,000 a year on prescription drugs, so the premiums for these customers are about $2,000 a year. So that's 4.4 billion in revenues. You're going to -- if you expect 4.4 billion in revenues every year, you wouldn't buy that asset for 100 million. That 100 million is a very low price.

And one way -- so it's consistent with this notion that WellCare knows that a lot of these 2.2 million customers are going to be lost, and that's why they're not willing to pay more than $107 million for this asset. So that's one explanation for it.

Another potential explanation for this is that maybe there was no one else who wanted to buy these assets, so WellCare was the only company and they got a good bargain.

But I think that is still concerning, because that says there's no potential entry in this market; that you are getting this great business and no one wanted -- came -- no one wanted to step up and enter this market. And so to me, that says that the potential for the -- there are significant entry barriers.

So whichever way you look at this transaction price, I think it raises significant competitive concerns. Either it means that this business is not going to stay viable and they're going to lose a lot of the Aetna customers or it means that there's no potential entry in this market, and I think both are concerning.

BY MR. QUILLEN:

Q Well, let's take your best-case scenario.

Let's say, despite all the disadvantages you've talked about, WellCare is able to hold on to every single Aetna customer that it acquired. Are there still regions of the country where you would have potentially significant competitive concerns nonetheless?

A Yes.

So if you look at Exhibit 20 or slide 20, I have listed seven regions where there would still be significant competitive concerns.

So just to give an example, the first region is Mississippi. There, the prediction is that in this

best-case scenario, where they are able to retain 100 percent of Aetna customers, which I think is unlikely, but even in that scenario, the Herfindahl Index arises by 230 points, the post-divestiture Herfindahl Index is 2,200, so the market is moderately concentrated, and WellCare's market share would be 21 percent, CVS's market share would be 31 percent.

Q And if you have a market where the Herfindahl Index rises that much and is moderately concentrated, if there's no real possibility of significant entry, what would you expect to happen to premiums?

A I would expect premiums to go up. And I think that would be consistent with the DOJ/FTC guidelines.

Q Is it consistent with the empirical literature you were just talking about as well?

A It is consistent with the empirical literature, as well as the theoretical literature.

Q Let's go beyond the best-case scenario.

Let's say that this new transaction makes WellCare such a fantastic competitor that it cannot only retain its Aetna subscribers but start taking market share from other larger competitors.

A Sure.

Q Is it possible that that could alleviate the concerns about concentration in these markets?

A So let's focus on Mississippi again, the first row.

And what we see is WellCare has, after the divestiture, a market share of 21 percent in Mississippi, and CVS has a market share of 31 percent.

So if you take some of CVS's customers and give them to WellCare, the market will become less concentrated, right?

And that is a scenario I have shown on the next exhibit, which is slide 21, in the last row.

So now what happens is WellCare starts taking customers away from CVS till their market share is equalized. So each now controls 26 percent of the market.

So even in this numerical scenario, where not only are they retaining 100 percent of Aetna's consumers, now they're actually getting consumers from CVS also, despite, as you said, CVS providing the key input to WellCare.

But even in this Goldilocks scenario, what we find is that the change in Herfindahl Index is 180, and --

THE COURT: Let me ask you to stop there a second.

THE WITNESS: Yes, sir.

THE COURT: The analysis that you've been doing and the studies you've been alluding to, do any of them discuss the likely, in this kind of scenario, the likely conduct that the CVS PBM will engage in if all of a sudden

WellCare is taking away its customers in the PDP arena?

THE WITNESS: Yes.

THE COURT: Would they stop being their PBM manager because it would be contrary to the interests of their PDP business? Or do they do an analysis on that? Or have you done any analysis of that?

THE WITNESS: Yeah.

So I do discuss that.

And basically, this, again, comes back to the original point of input foreclosure.

So basically if WellCare starts taking away PDP business from CVS, CVS, the PBM, has an incentive to disadvantage WellCare.

So they could disadvantage them by not passing on all the rebates they're getting from the manufacturer back to WellCare. They could disadvantage them by not negotiating hard with pharmacies. They could disadvantage them by increasing the administrative costs for WellCare.

THE COURT: Could they require that the customers only get their pharmaceutical drugs at CVS/Pharmacies and they can't go to any other pharmacy? Could they do that?

THE WITNESS: I'm not sure of that.

So I think they can advantage CVS/Pharmacies in several ways.

THE COURT: Like a bigger co-pay?

THE WITNESS: Yeah.

THE COURT: Excuse me. A smaller co-pay.

THE WITNESS: A smaller co-pay.

THE COURT: Smaller.

THE WITNESS: Or advertising the CVS brand more.

But I don't know if they can prohibit you from -- I think that would be a very restrictive --

THE COURT: Yeah.

THE WITNESS: -- pharmacy network if you just say, You can only get your drugs from CVS and nowhere else. I think, you know, a lot of consumers would be up in arms about that, and that is probably one of the reasons that might not happen.

THE COURT: No.

THE WITNESS: And you're right. In the end, they could also -- if they think they're losing a lot of market share, they might decide to not provide PBM services to WellCare.

THE COURT: Don't make a bid?

THE WITNESS: Yeah.

So that is a possibility.

BY MR. QUILLEN:

Q And looking at what you have done on slide 21, then, would it be accurate to say that there are four markets in which it's mathematically impossible to get the

increase in concentration back below a level of concern just by virtue of WellCare increasing its market share against CVS?

A Yes, that is accurate.

Q And two of those rows are in bold. Can you explain why those are in bold?

A So in two of those rows, now, what happens is that WellCare has the highest market share, which means even if it takes customers from other competitors in this market, that would only increase the Herfindahl Index.

So in this scenario, it's basically, you cannot have the Herfindahl Index going down anymore.

So the best, best-case scenario in these markets is still the Herfindahl Index rising by more than 100 points and the post-divestiture index being above the 1500 threshold.

So the best, best-case scenario in this market still raises significant competitive concerns; that no matter how strong WellCare becomes, you would still have significant competitive concerns, according to the DOJ/FTC guidelines.

BY MR. QUILLEN:

Q And in those -- those markets, Arkansas, Mississippi, that means that even if WellCare could somehow take market share from any competitor it wanted in such a

way that it was making the Herfindahl Index as low as mathematically possible, it would still be above levels of concern?

A Yes, sir.

Q Are there concerns, like the ones we've just been discussing, specifically with respect to low-income enrollees?

A They are.

So the DOJ, in its competitive impact statement, it said that in 9 regions, the merged company will account for between 35 percent and 55 percent of all low-income, subsidy-eligible beneficiaries.

So this was after the merger but with no divestiture.

So now, given the divestiture, some of these problems still remain.

So in two markets, WellCare will account for more than 35 percent of the low-income, subsidy beneficiaries.

So this original concern that DOJ raised is not fully solved by the divestiture.

THE COURT: That's Arkansas and Hawaii?

THE WITNESS: That's Arkansas and Hawaii. You're correct.

BY MR. QUILLEN:

Q What are your expectations of WellCare's abilities

as a competitor going forward versus Aetna's ability to compete before the merger?

A Sure.

So I think WellCare is a much weaker competitor than Aetna, and I have three reasons to think that.

First is, Aetna has a much stronger brand than WellCare. So when customers were given a choice to choose between a WellCare plan and an Aetna plan, more customers chose Aetna compared to WellCare.

The second is that Aetna is -- as you said, it has 2.2 million beneficiaries in the PDP market, but it is a much bigger insurer. It is -- overall, it has about 20 million --

THE COURT: 21 million.

THE WITNESS: -- subscribers.

So that gives it more clout when it's negotiating with pharmacies and when it's negotiating with manufacturers, which WellCare doesn't have.

So I think that bigger sizes allows economies of scale better bargaining power for Aetna compared to WellCare.

And that is also evident from what has happened in this market.

As I mentioned earlier, Aetna has been able to increase its market share from 2 percent to 9 percent before

the transaction, and WellCare wasn't able to increase their market share so dramatically.

So all these three factors kind of say that WellCare was a much stronger competitor than -- sorry. Aetna was a much stronger competitor than WellCare.

THE COURT: In the PDP arena or in general?

THE WITNESS: I'm talking specifically in the PDP arena.

But it could apply more generally. I haven't looked at it.

THE COURT: Okay.

BY MR. QUILLEN:

Q And I know we've touched on this a couple of times so far; but to put a finer point on it, what are your views on the likelihood that entry into the PDP market will alleviate some of the competitive concerns we have been discussing?

A So I think there are significant barriers to entry in this market.

And I have in one of the exhibits a statement by the DOJ, where they basically agree or I agree with their assessment. That's slide 32.

And where they state that "Neither entry nor expansion is likely to solve the competitive problems created by this merger between CVS and Aetna. Recent

entrants into the individual PDP market have been largely unsuccessful, with many subsequently exiting the market or shrinking their geographic footprint.

"The effective entry into the sale of PDPs requires years of planning --

THE COURT: Slow down a little bit. My reporter, he's very good, but you're going pretty fast there.

THE WITNESS: Okay.

"Effective entry" -- is that fine?

COURT REPORTER: Yes.

THE WITNESS: "Effective entry into the sale of individual PDPs requires years of planning, millions of dollars, access to qualified personnel, and competitive contracts with pharmacies and pharmaceutical manufacturers."

Because of these barriers to entry, entry or expansion into the sale of individual PDPs is unlikely to be timely or sufficient to remedy then anti-competitive effects from this merger.

And as I said, the paper by the Princeton researchers also found that after the first two years, there was not -- there wasn't any entry into this market.

So I think the structure of this market, as well as past experience, are consistent with significant entry barriers.

BY MR. QUILLEN:

Q So when you see an increase in concentration in this market, do you have any reason to believe that it would not lead to an increase in premiums?

A I don't have any reason to believe that it will not lead to an increase in premiums.

Or to state it another way, you know, the analysis shows that in several markets, if WellCare is unable to aggressively compete with CVS, there would be significant competitive concerns, and those competitive concerns would not be mitigated by entry into these markets.

Q I'd like to talk about some of the arguments about the efficiencies that this transaction might create.

Before I do, is there anything else you wanted to say about the PDP market specifically?

A I think -- I would just like to summarize the main points so far, which is that, first, we have to remember that the public in this PDP market are Medicare beneficiaries. They are older. They are low income. They have multiple health conditions.

So this is not like a luxury car market where prices go up and we can argue whether the public would be hurt or not. The public here is really vulnerable. So if premiums go up, that will have a big impact on consumers in this market.

The second point I want to summarize is that the numbers show that, you know, no matter what scenario you assume, there are always some markets where there will be significant competitive concerns, which is, no matter how strong WellCare gets, there are still some markets where significant competitive concerns raised -- are there.

My expectation is that the competitive concerns will not only remain in those two markets but in many more markets because I don't think WellCare is a strong competitor relative to CVS or Aetna. They don't have the same brand. They get PBM services from CVS itself. They don't have the same economies.

The third thing is the empirical evidence here is clear; that a loss of a competitor such as Aetna or loss of any competitor raises premiums in these markets. And that's consistent with both theory and empirical evidence.

So I think the potential for harm here is real.

Q Are you aware of any efficiencies that this merger and divestiture might create in the PDP market specifically?

A No.

And I think the reason for that is so if you look at the combined transaction, the merger and the divestiture, this is not now a merger in the PDP market, right, because Aetna's assets have now been divested to WellCare.

So Aetna and CVS are actually not merging in the

PDP market, which means there cannot be any PDP-specific efficiencies because there is no PDP-specific merger here.

And even if you now relax the scenario, so suppose you say the divestiture doesn't happen and now there is a merger in the PDP market, so Aetna and CVS merge in the PDP market, the DOJ, in its own assessment of this merger, has noted that they did not -- and, you know, I have the exact quote -- but they did not find merger-specific, verifiable efficiencies that would outweigh the competitive concerns.

So the DOJ agrees that even if there was a PDP-specific merger, there are no merger-specific -- or the merger-specific efficiencies are unlikely to outweigh the competitive concerns.

But I think the more important point is that there is no PDP-specific merger between CVS and Aetna and the PDP market.

THE COURT: So in assessing whether or not this merger, as currently constituted, with the divestiture --

THE WITNESS: Yes.

THE COURT: -- in assessing whether or not the merger as currently constituted is in the public interest or not -- which is my job, right?

THE WITNESS: Yes.

THE COURT: -- should I limit myself to the impact on the PDP market alone? Or should I look to the broader

sense of how the entities that have merged here are going to impact the greater market, the non-PDP market?

THE WITNESS: That is a very loaded question.

THE COURT: Well, give it your best shot.

THE WITNESS: So, you know, in my earlier testimony, I've said that the merger raises competitive concerns in other markets also.

So from my personal point of view, you know, those -- there are competitive concerns in those other markets.

I don't understand the law as well as most people in this room. So I don't know -- but I think the merger -- so if you're asking me for my assessment that -- would the public be affected in these other markets as a result of these mergers?

Yes, they would be.

THE COURT: Well, when the Justice Department filed its complaint opposing the merger prior to the divestiture remedy, they were saying it was broader than just the PDP market, weren't they?

THE WITNESS: I'm not sure.

My understanding is that their complaint was limited to the PDP market, and they downplayed the vertical concerns in the other markets. They didn't think they were significant enough.

THE COURT: Do you see the efficiencies in the other market here? Do you see efficiencies?

THE WITNESS: So there have been efficiency claims in these other markets, and I'm -- so let me comment on them.

So one of the efficiency claims is that this merger will lead to innovation in healthcare delivery, which is CVS stores are going to be transformed into these healthcare hubs.

THE COURT: You mean those one-minute-limit entities?

THE WITNESS: One-MinuteClinics.

THE COURT: Clinics.

THE WITNESS: Maybe MinuteClinics or maybe beyond that.

But the way I look at this is, so if you want to innovate in healthcare delivery, maybe you want to partner with people who are experts in healthcare delivery.

Aetna is an insurer. It is not in the business of healthcare delivery. It's in the business of insuring people.

So then you might ask, So what you'd want to do is come up with a new model.

And then that model has to pass the market test, which means, if you're providing high-quality care at low

price, customers would want to come to your MinuteClinic or healthcare club or so on.

I think what this transaction is doing is it's buying customers.

So when you buy Aetna, the insurer, you can now potentially steal Aetna subscribers to your new healthcare delivery model.

THE COURT: That's 21 million subscribers.

THE WITNESS: 21 million.

But now those 21 million subscribers are lost to other innovators in this market.

Maybe there's a better model in the healthcare hub. Maybe there's a new app. And whatever it is, those -- so those innovators are going to lose out.

So in that sense, I don't think this promotes innovation because it blocks some of these 21 million customers from using other innovative models.

I'm all for innovation. But I think that innovation has to pass the market test which has forced you to innovate. And if you're selling a good product at a high quality, people would buy that.

The second efficiency claim that has been made in these other markets is that the merger will allow for the integration of medical data, with pharmacy data, and that will make CVS a better PBM for Aetna.

So -- but if you look at Aetna's press release when they initially signed an agreement with CVS, it -- and I think I have it as an exhibit.

THE COURT: Well, I'll tell you what. We're going to take the luncheon recess, okay?

THE WITNESS: Okay.

THE COURT: You'll be back after lunch, and you'll still have another half hour or so to testify, all right?

THE WITNESS: Okay.

THE COURT: And you can go into some of those things at that point.

THE WITNESS: Sure. That would be great.

THE COURT: All right.

So we're going to continue our conversation here; reconvene at 2:00. So be back and ready to go at 2:00.

THE WITNESS: Yes, sir.

THE COURT: And you can step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Thank you.

Ladies and gentlemen, we'll be returning at 2:00.

And like I said before, we won't be going any later than 5:30. But we're going to get the two other witnesses -- we're going to finish this witness, and we're going to get the two other witnesses in this afternoon.

We'll take a break until 2:00 in the afternoon.

I've strained my wonderful court reporter's patience here by going an hour and a half, but I think he'll survive.

So see you at 2:00.

MR. QUILLEN: Thank you, Your Honor.

DEPUTY CLERK: All rise.

(Proceedings concluded at 12:16 p.m.)

C E R T I F I C A T E

I, William P. Zaremba, RMR, CRR, certify that the foregoing is a correct transcript from the record of proceedings in the above-titled matter.

Date: June 4, 2019_____ /S/__William P. Zaremba_____

William P. Zaremba, RMR, CRR